

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/06/2012  
FORM APPROVED  
OMB NO. 0938-0391

45th 8/19/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445501	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/05/2012
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NAME OF PROVIDER OR SUPPLIER

WEST HILLS HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE

6801 MIDDLEBROOK PIKE  
KNOXVILLE, TN 37919

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on medical record review, interview, and review of facility policy, the facility failed to provide related social service follow up regarding advanced directives for one resident (#7) of twenty-three residents reviewed.  The findings included:  Resident #7 was admitted to the facility on November 9, 2005, with diagnoses including Esophageal Reflux, Parkinson Disease, Hypothyroidism, Osteoporosis, Bipolar Disease, and Dementia.  Medical record review of the quarterly Minimum Data Set (MDS), dated June 16, 2012, the resident scored a 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident	F 250	F250 1. Resident #7 was interviewed by Social Service Director on 7/3/12. An interdisciplinary note was entered in the medical record to reflect the current code status by the Social Service Director. The resident's current code status reflected the resident's wishes.  2. An audit of the social service assessment was completed on 100% of residents on 7/3/12 by the Director of Nursing, Social Service Director, Regional Nurse, and Assistant Director of Nursing. All resident's current code status reflects the current code status order in the medical record.  3. The Social Service Director was in-serviced on 7/12/12 by the Director of Nursing to compare the Social Service Assessment information to a resident's medical record information to ensure accuracy. The Social Service Director will compare the Social Service Assessment to the medical record to ensure information is correct. The Social Service Director will inform the Assistant Director of Nursing/Director of Nursing to obtain clarification from Responsible Party/Power of Attorney for Health Care if	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Daren Sumner RN* *Director of Nursing* 7/18/12

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 250

Continued From page 1  
was cognitively intact.

Medical record review of the Physicians Orders for Scope of Treatment (POST) form, dated June 25, 2002, revealed the resident's code status indicated "Resuscitate, Cardio Pulmonary Resuscitation (CPR) and full treatment (CPR, intubation and mechanical ventilation).

Medical record review of the Case Management Assessment, dated October 13, 2010, revealed "...DNR: Y/N ("N" (no) was indicated on the assessment)...full tx (treatment), abx (antibiotics), IV (Intravenous), FT (feeding tube) long term..."

Medical record review of the Social Services Admission Assessment, dated February 27, 2012, revealed "...Advanced Directives...DNR (do not resuscitate)...Durable Power of Attorney..."

Interview with the Licensed Medical Social Worker (LMSW), on July 3, 2012, at 1:40 p.m., in the Social Service Office, revealed the assessment was conducted with the resident and the resident indicated a "DNR status". Further interview with the LMSW confirmed the social service assessment and the POST form were inconsistent and the resident was a "full code". Continued interview confirmed the social services had not followed up to clarify the resident's desires related to the advanced directives.

Interview with the Director of Nursing (DON), on July 3, 2012, at 1:50 p.m., in the Nurses Station, confirmed the social service assessment revealed the resident was a DNR and the POST form revealed the resident was a full code.

F 250

any discrepancies. The Social Service Director will inform the Assistant Director of Nursing/Director of Nursing to obtain clarification from physician. The administrator or Director of Nursing will randomly audit the Social Service Assessment weekly times four weeks, then monthly to ensure the assessment and the medical record match.

4. All findings will be reviewed by the Director of Nursing in the Quality Assurance Performance Improvement Committee meeting for three months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.

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F 250	Continued From page 2 Interview with the facility administrator, on July 3, 2012, at 3:15 p.m., in the administrator's office, confirmed "...the resident has been a full code since admission to the facility and the resident confirmed today the full code status". Further interview revealed "...the social service director could not remember if the resident gave an interview for the DNR status or if the documentation was an input data problem..." Continued interview with the administrator confirmed the social service assessment and the POST form were inconsistent and the social service had not followed up to clarify the resident's desires related to the advanced directives.	F 250			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 1. Resident #11's care plan was updated to reflect a fall on May 27, 2012 by Assistant Director of Nursing. The 2567 incorrectly states date of fall as May 28, 2012. Resident #11's care plan was updated to reflect the fall on June 14, 2012 by the Charge Nurse and Restorative Nurse.  2. Residents, with falls for the last 3 months, were audited on 7/3/12 by the Regional Nurse, Director of Nursing, and Assistant Director of Nursing. There were no other residents affected.  3. All nurses will be in-serviced on updating the care plan, after a fall, by Assistant Director of Nursing, Director of Nursing, Unit Manager by 7/18/12. The Unit Manager will review the falls investigation/report to ensure all parts of the investigation are attached to the investigation report. The Director of Nursing		

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F 280	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview the facility failed to update the care plan after two falls for one resident (#11), of twenty-three residents reviewed.</p> <p>The findings included:</p> <p>Resident #11 was readmitted to the facility on March 11, 2011, with diagnoses including Anemia, Hypertension, Neuropathy, Dementia, Depression, Anxiety, Cellulitis, Sciatic Nerve, and Chronic Obstructive Pulmonary Disease.</p> <p>Medical record review of the quarterly Minimum Data Set (MDS), dated June 4, 2012, the resident scored a 12 on the Brief Interview for Mental Status (BIMS) which indicated the resident was moderately impaired.</p> <p>Medical record review of physician's progress notes revealed the resident had fallen on May 28, 2012, and again on June 14, 2012.</p> <p>Medical record review revealed the resident's care plan related to falls had not been updated since May 27, 2012. The quarterly review of the care plan was done on June 11, 2012, with no changes or documentation of the falls on May 28, 2012, and June 14, 2012.</p> <p>Review of the facility's policy "Care Plan - Comprehensive" last revised in August 2006, revealed "...care plans are revised as changes in the resident's condition dictate..."</p>	F 280	<p>and/or the Assistant Director of Nursing will review all fall investigations/reports Monday through Friday in the Clinical Meeting to ensure the fall investigation/ report is completed to include the updated care plan ongoing.</p> <p>4. All findings will be reviewed by the Director of Nursing in the Quality Assurance Performance Improvement Committee meeting for three months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.</p>		7/18/12

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F 280	Continued From page 4	F 280			
F 372 SS=D	<p>Interview with the Assistant Director of Nursing on July 2, 2012, at 3:15 p.m., at the second floor nurse's station, confirmed the resident's care plan under falls had not been updated to reflect the two falls.</p> <p>483.35(i)(3) DISPOSE GARBAGE &amp; REFUSE PROPERLY</p> <p>The facility must dispose of garbage and refuse properly.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a sanitary environment in the dumpster area for one of one dumpster outside.</p> <p>The findings included:</p> <p>Observation of the compactor dumpster with the Registered Dietitian on July 2, 2012, at 9:45 a.m., outside the facility, revealed liquid refuse leaking from the compactor dumpster, was running onto the concrete slab under the dumpster, and down the adjacent asphalt. The leakage was greenish in color and produced a strong, foul, and soured odor.</p> <p>Interview with the Maintenance Director on July 2, 2012, at 9:48 a.m., at the dumpster site, revealed the compactor dumpster had "...a busted seal that caused the leakage when the dumpster was full..." and confirmed the facility failed to ensure the proper containment of garbage and refuse.</p>	F 372	<p>F372</p> <p>1. No residents were identified as having been affected. The liquid around the dumpster was immediately cleaned by the maintenance assistants on 7/2/12. The dumpster was resealed on 7/13/12 by the Waste Management of Knoxville.</p> <p>2. There are no other dumpsters at the facility.</p> <p>3. The administrator in-serviced the maintenance on proper containment of garbage on 7/2/12.</p> <p>4. The maintenance director will audit the compactor dumpster weekly times 3 months to ensure the seal remains intact. The Administrator will randomly audit the compactor dumpster monthly times 3 months and ongoing during monthly preventative maintenance rounds to ensure the seal is intact. All findings will be addressed in the Quality Assurance Performance Improvement Committee for three months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.</p>		7/18/12

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